Brent

Central and North West London NHS
NHS Foundation Trust

Services provided and their rating:

Service	Type	Overall Trust Rating	Local Brent Provision
Acute wards for adults of working age	Mental health	Inadequate	Pond Ward, Pine Ward, Shore Ward
Mental Health Psychiatric Intensive Care Units	Mental health	Inadequate	Caspian Ward
Mental Health Crisis Services and Health Based Places of Safety	Mental health	Good	Park Royal Mental Health Centre
Ward for older people with mental health problems	Mental Health Services	Requires Improvement	Butterworth Centre
Mental Health Services	Long stay rehabilitation mental health wards for working age adults	Good	Fairlight
Community Based Mental Health Services for Older People including Memory Services	Mental health	Good	Fairfields House, Central Middlesex Hospital,
Community Based Mental Health Services for Adults of Working Age	Mental health	Requires improvement	Brondesbury Road, Pary Royal Mental Health Centre, Roundwood Centre, Central Middlesex Hospital,
Specialist community mental health services for children and young people	Mental Health Services	Good	Bell House, Warranty House,
Learning Disability Services	Mental health	Inspected but not rated	Brent and Harrow Community Team (Learning Disabilities)

Trust wide areas of good practice

The CQC noted that the positive attitude of staff was very evident throughout the inspection. This was reflected in their pride in working for the trust and their service and in their wish to provide the highest standards of care to people using the service.

The pharmacy team not only ensured that the arrangements for the supply of medicines was good, but also provided considerable guidance and support to staff and patients throughout the services.

Patients, carers and staff all valued the courses provided by the recovery college and the opportunities for personal development. The recovery college was very well organised and responsive to local need.

Please note that 'must do's' identified by the CQC are made for core services areas, and therefore not all will be applicable to the borough's services.

Acute Wards for Adults of Working Age

Areas of good practice:

- The wards all had access to information to monitor and audit quality through data extracted from the electronic record system.
- Generally the CQC found that patients spoke very positively about the support they received from the staff. They said staff were helpful, caring, listened to them and gave them encouragement and support with their needs. Most of the patients spoke of being involved in their care and support planning
- CQC observed positive, kind and caring interactions between staff and the patients, including under challenging circumstances.
- Acute services were effective. Clinical staff made assessment of patients' needs including physical care on admission to wards. Where needs were identified, the care plans reflected those needs.
- Multidisciplinary teams worked effectively together in caring for and supporting patients.
- The staff in acute services were kind and respectful to patients and had a good understanding of individual needs. During MDT meetings, CQC observed that patients and their relatives were encouraged to express their views.
- In 2014 the acute care services introduced daily 'whiteboard' meetings on each ward. These were attended by a range of disciplines including the consultant psychiatrist, matron, staff nurse, psychologist, pharmacist, occupational therapist and medical trainees. The meeting provided a daily update on each patient and opportunity for professions to have daily oversight of what was happening with each patient.

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Areas for improvement:

12 x 'must do's'

1. The Trust must address the blind spots in the ward environment of Park Royal MHC to enable clearer lines of sight and reduced risks to patients and staff.
2. Staff working on the wards must be able to articulate how they are assessing and managing the potential risks from ligature points for the patients using this service. The use of blanket restrictions must be reviewed and risks from ligatures managed to reflect the needs of the patients on the ward.
3. The provider must ensure that staffing levels are adjusted to reflect the actual numbers of patients on the wards. This number must include those patients spending the day on the ward even if they are sleeping on another ward or at another hospital overnight.
4. The Trust must implement the training of all staff in new restraint techniques to ensure that staff working together on wards are all trained in the same techniques and in line with current best practice on the use of prone restraint, to prevent injury to staff and patients.
5. Staff must always monitor and record physical vital signs in the event of the use of rapid tranquilisation until the patient is alert. They must improve medical reviews of patients receiving rapid tranquilisation to ensure patients are not at risk.
6. The Trust must take further steps at the Park Royal MHC and other sites where acute inpatient services are provided to ensure that risks to detained patients from being absent without authorised leave are minimised.
7. The Trust must ensure that, on admission to a ward, patients have a designated bed that is within the ward occupancy levels.
8. Patients returning from leave must have a bed available on their return to the ward.
9. The Trust must take steps to reduce the number of times that patients are moved to other wards to sleep for non-clinical reasons. Where it is unavoidable, staff must ensure that a thorough handover takes place to promote continuity of care. Patients must only be moved at reasonable times so that they are not adversely affected.
10. The Trust must promote the privacy and dignity of patients. Patients must be able to make calls in private.
11. The Trust must ensure the acute wards for adults of working age are well led by having contingency plans in place for when the numbers of patients needing a bed increases above the beds available.
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Mental Health Crisis Services and Health Based Places of Safety

Areas for improvement:

2 x 'must do's'. 4 x 'should do's'

Must do's

- The Trust must ensure that when a person is assessed as requiring an inpatient bed that they are able to access a bed promptly.
- The Trust must ensure that the access to the Trust's places of safety promotes the patient's dignity and privacy by the provision of a separate entrance.

Should do's

- Risk Assessments should be updated on the Trust's electronic record system to reflect changing risk.
- Lone Working should be reviewed to ensure all teams have a robust system.
- A patient's capacity to make a decision should be recorded in the written records.
- Team to consider ways of collecting regular feedback from service users.

Mental Health Psychiatric Intensive Care Units

Areas for improvement:

1 x 'must do'. No 'should do's'

- The Trust must ensure information is available to inform patients on how to make a complaint. They must ensure verbal complaints are addressed and, if needed, patients and carers have access to the formal complaints process.

Community Based Mental Health Services for Adults of Working Age

Areas of good practice

- Almost all services had employed peer support workers, people who had used or were using mental health services, who were a positive addition to the teams.
- Several community services involved patients in interviewing prospective new staff members as part of the recruitment process.
- Most teams held regular forums for patients and carers to give feedback about the service.

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Areas for improvement:

3 x 'must do's'. 4 x 'should do's'

Must do's

- The provider must ensure that where automated external defibrillators (AEDs) are provided because there is a clinical need for this equipment, for example at Hillingdon community recovery team (Pembroke Centre) that they are maintained on a regular basis, accessible and available for use. The provider must ensure that other teams also have resuscitation equipment if needed.
- The Trust must ensure there are sufficient staff available to work as care co-ordinators so that duty workers in some services are not holding large numbers of patients which could potentially create a risk for the safety and welfare of patients
- The provider must ensure that patients using community services are referred for regular physical health checks.

Community Based Mental Health Services for Older People including Memory Services

Areas of good practice

- Services are thoughtful, considered & respectful, working closely with relatives.
- Staff have access to training to support them in their job role.
- There are clear processes for reporting and learning from incidents.
- Very good use of the Mental Capacity Act to support decision making.
- Staff used NICE guidance to deliver service.
- There are strong triage systems in place to ensure people are seen in a timely manner.
- There are good processes in place to follow up DNAs and cases are closed on an individual, considered basis.

Areas for improvement:

0 x 'must do's'. 4 x 'should do's'

- Care Plans should include a full physical healthcare management plan where physical health care issues are noted on initial assessment.
- The teams should explore if care plans can be provided in a more accessible format.
- The services should ensure all staff have access to regular supervision.
- The services should collate informal verbal complaints so that lessons can be learnt from these.

CAMHS

Areas of good practice:

- The Brent CAMHS service ran the targeted mental health in schools (TaMHS) programme. They worked to support school staff to recognise young people with emotional wellbeing and mental health needs. They provided access to advice and consultation from a professional in mental health.
- Incident reporting and learning from incidents was apparent across teams. Staff had been trained and knew how to make safeguarding alerts. Staff managed medicines well.
- Young people referred to teams were seen by a service that enabled the delivery of effective, accessible and holistic evidence-based care.
- Staff demonstrated their commitment to ensuring young people received robust care by being proactive and committed to people using the service, despite the challenges with limited resources.
- There was strong leadership at a local level and service level across most of CAMHS that promoted a positive culture within teams.
- There was a commitment to continual improvement across the services.
- Young people were used on interview panels and had been involved in developing interview questions.

Areas for improvement:

0 x 'must do's'. 0 x 'should do's'

This section contains actions that are being taken, or are already in progress, in response to the findings presented in the CQC reports. Our conversations with you will help shape these actions and deliver a robust action plan back to the CQC.

The following actions are underway to address the 'Must do's' and 'Should do's':

Safe environment and safe care:

- The Team reviews Care Plans and Risk Assessments weekly at the Clinical Review Meeting.
- Monthly audits completed by Team Doctor and staff members.
- Where blind spots/lines of sight is an issue, wards have agreed day-to-day management of these ward areas through ward zone observation, allocating staff responsible for observing the affected areas. [Completion 12 June 2015]
- All ward environments have been assessed and mirrors ordered to address blinds spots / clear lines of sight identified. Update at 12 June 2015: St. Charles MHC, Park Royal MHC, Riverside Centre, acute wards at Northwick Park MHC and Seacole Centre at Kingswood have so far been completed. The installation programme will be completed by 20 July 2015.
- Ligature risks have been identified in each ward and documented in risk registers held in each of these clinical areas. Each ward has specific ligature

risks identified and documented. It is imperative that ligatures that are identified as requiring local management and are fully understood by staff and included in staff supervision structures and MDT ward rounds.

- The ligature risk registers are reviewed on a monthly basis via the work place risk assessments. The Ward Managers and local Estates Lead conduct the monthly reviews.
- The ligature risk assessments are reviewed at the bi monthly estates and facilities meetings, where all ward managers attend, with the local estates lead and matrons.
- There is a Trust Wide Ligature removal programme led by one of the corporate Estates Officers, who oversees this programme. The programme is then reviewed at regular estates meeting.
- The ligature risk audit is completed on an annual basis and this is led by the Trust Health and Safety Department and the Estates Team. The above programme is monitored by the service manager.
- Ligature risk competency framework and training programme has been developed. The expected outcome of this programme will be that all staff will be able to fully articulate the way that ligature risks will be managed in their wards, Nursing Care Plans and shift by shift entries are audited on a regular basis, and individual patient care plans being linked to identified ligature risks according to patient and environmental risks will be monitored, and reported at ward level.
- Datix incident reports are monitored by the Matrons and service manager and all episodes of self-harm are responded to with the individual team (including Consultant Psychiatrist) providing assurance on care and treatment plans.
- The Trust Risk Assessment policy includes a review of suicide and self-harm risk and individual patients presenting with ligature tying risks, or general risk of suicide or self-harm are identified and these issues are managed across the Multi-Disciplinary Teams on an ongoing basis.
- The observation and engagement policy provides the practice framework for managing self-harm risk via therapeutic engagement and enhanced one to one observation for patients identified as presenting significant self-harm risks
- Statistics on the use of close observation are monitored via the daily Trust wide bed capacity reports.
- A memo communication was sent to all staff on 21 May 2015 to raise awareness / remind staff of the monitoring/review requirements when administering rapid tranquilisation, for example, noting the reason for the administration, and the on-going reviews of the patients' physical health following the rapid tranquilisation administration. [Completed 21 May 2015]
- Since May 2015, fortnightly audits are being carried out by the Divisional Governance Team to monitor the completion of vital signs monitoring following rapid tranquilisation, and the reason is specified. The results, by clinical team, are fed back to ward managers and the lead clinician for immediate follow up action, and are discussed at team meetings, handovers, and during staff supervision. Results are monitored by the Divisional Director of Nursing. Results at June show improvements have been made, with an aim of achieving 100%.
- The Trust has undertaken a Security Review of all acute in-patient wards: the report from this was agreed by the Operations Board, chaired by the Chief Operating Officer on 23rd April 2015.
- As a result, the actions we are implementing have been designed to support a reduction in the number of people absconding from the wards and has set a target to reduce this by 50% by 1 April 2016.
- The Trust is now designing an e-learning package that will be essential to role for all staff, to be completed prior to working within the in-patient environment. This training package will be in place by 31 July 2015. The training will be delivered to all existing staff over 8 weeks and new staff will complete this as part of their local induction. Where Agency staff are employed, hardcopy versions will be delivered by ward managers. Whilst the e-learning package is being designed, the Trust has put in place Interim Security and Safety Guidance; this has been distributed to all staff working at acute in-patient sites.
- A Security Review has been completed; this identified that 'tailgating' (i.e. closely following a visitor or staff member through an exit) is a primary cause of absconsion.
- Work has begun to remove all door release buttons, located in nursing offices, to assist in the prevention of tailgating and guidance on relational security is included in the Interim Security and Safety Guidance, to ensure that a member of staff is by the ward entrance door to greet visitors or authorise guests.
- A review of the physical security infrastructure has been conducted and works at those sites identified by the CQC have been prioritised. There are plans for additional doors to increase the 'layered approach' to security (i.e. the additional doors will combine with existing security controls to further minimise the risk of absconsion) where necessary.This work will be completed by 5th December 2015. The remote door release has been removed from all the doors, this means that only staff with a swipe card reader can enter or exit the ward. All other individuals will need to be let on or off the ward.
- Work is ongoing with inpatient staff (multi-disciplinary teams) to ensure that where risk of absconsion for a patient is identified as a result of a risk assessment that the risk management plan is reflected in the patient's care plan. This is being addressed through local Quality Governance Groups and Team Meetings. Care plans are regularly audited by Ward Managers and Clinical Team Leaders.
- The AED Standard Operating Protocol clarifies that staff are to keep a record of daily checks on the AED including that:

  i - it is in place and serviceable with a green light displayed on the AED

  ii - the attached pads are in date

  iii - a razor and shears are immediately available with the AED

  iv - There is immediate access to spare pads and battery or an alternative AED
- Team Managers will monitor that these checks are being recorded and sign the completed forms each month. The AED Standard Operating Procedure has been circulated to all adult community mental health teams, which includes the explanation around AED maintenance and that an annual maintenance check is expected from BCAS and that this will be reflected on the sticker on the AED.
- Audits are completed to ensure each risk has an associated care plan results are fed back to care coordinators and where risks are found without a care plan remedial action is taken.
- All service users have their physical health care needs assessed on initial assessment and then every 6 – 12 months.

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Dignity and privacy:

- Private patient telephone calls: Access to private phone calls is available for all patients. This is via cordless telephones, telephone booths or the ability to make mobile phone calls from patient bedrooms.

Staffing:

- There is a local Lone Working Policy for Brent HTT. This is under review currently to incorporate an alert system. The local policy will be in line with the new Trust wide Lone Working Policy.
- Staffing levels are adjusted reflecting the changing clinical risks and patient number of a ward to ensure patient safety and comfort. This is monitored and reviewed on a daily basis.
- All team members have access to regular clinical supervision and this is being monitored by matrons.

Safeguarding service users from abuse and patients not being protected against the risk of unsuitable control or restraint:

- The Trust is now training all relevant staff who may be required to use physical intervention in the delivery of an alternative technique to the prone restraint position.
- As of 1 June 2015, 314 (57%) staff have been trained in the alternative supine position.
- The remaining 237 (43%) members of staff are due to receive their update by July 2015.
- Where wards have seclusion rooms a seclusion log is in place, which is completed on every episode of seclusion. The log will document that medical and nursing reviews have taken place and is monitored by the ward manager and Matron. Issues will be highlighted at team meetings as required, and any specific practice issues followed up in clinical supervision. [Complete May 2015]

Care and welfare of people who use services:

- There is an HTT service user questionnaire to collect feedback from service users. The feedback is evaluated and fed back on a monthly basis.
- The Trust will explore other relevant formats for care plans to be provided in a more accessible format to meet the accessibility requirement of patients.

Bed Management:

- Bed availability is reviewed at weekly bed management meetings and through the scrutiny of daily out of hours senior manager on call reports with a process of escalation to address any delays.
- **Local ownership:** bed occupancy is discussed at least twice daily with Borough and Clinical Directors
- New Place of Safety Project underway and led by Estates. A separate entrance will be provided in the new suite.
- The number of patients who have slept out or been moved has reduced to a minimal level.
- The overall aim of the Trust's bed management process is to reduce the bed occupancy rate to 95% by 1 June 2016.
- Immediate Actions we have taken:
  - **Stopped admission** of adults to older adult wards
  - **Greater central oversight:** set up centrally-led 3 x weekly bed management meetings, chaired by the Chief Operating Officer, at which we discuss/review:
    - all 4, 8, 12, 24 and >24 hour breaches;
    - monitor the number and reasons for patients staying over 60 and 100 days;
    - community and home treatment team engagement in preventing unnecessary admissions, and
    - community team provision of support in progressing delayed discharges and work together to resolve unnecessary delays.
  - **Escalation process** both in and out of hours to manage patient flow put in place.
  - **Improved information flow:** twice daily (morning and evening) bed state disseminated across the Trust
  - **Use of ECR beds:** we are using ECR beds as and when necessary with the support of funding from commissioners - these conversations are ongoing.
  - **Engagement of stakeholders:** Borough Directors are currently working closely with our local authority and commissioner colleagues in managing delayed discharges. This is on-going.

Quality of service provision:

- Care coordinators to review all care plans to ensure each one has a crisis plan – end June 2015.
- Where crisis plans are not in place care coordinator to ensure one is developed within 4 weeks with the service user - end July 2015.
- Quarterly Peer Audits of Crisis Plans will be undertaken commencing July 2015.

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Complaints:

- New complaints posters and leaflets have been designed and displayed in patient/public areas. [Completion 12 June 2015]
- Spot checks by service managers/matrons to ensure these posters are up and leaflets available to patients, special confirmation to be received from the Ward managers for PICU's. [Completion 30 June 2015]
- Our new DatixWeb system is used to capture all patient feedback, including concerns and complaints, verbal and written. DatixWeb allows regular reports to check verbal concerns and complaints are being logged and acted on.

  Staff have been briefed of this requirement via the Trust's weekly news, and a series of communication and this is supported by the new Patient Feedback Policy. [Completion 31 July 2015]

  The revised Patient Feedback Policy and procedure currently being consulted on with a view to launch by 30 June 2015, and includes the requirement to record verbal concerns and complaints on DatixWeb. [30 June 2015]
- Informal complaints are discussed as they come in will be discussed at the monthly community quality and management team meeting.

Respecting and involving service users:

- Patient capacity to make a decision is audited weekly using a proforma.

CAMHS:

- Triage system is in place; process in place reiterated to staff which is beginning to address the high demand on the service.
- The service has reissued and discussed the Lone Working Policy and procedures and managers have been asked to review alarm systems.
- Care and Crisis Plan - all staff reminded to discuss this with service users and record that this has been done. Service users to be given a crisis card.